# Physician Group **REFERRAL FORM**

OntarioBreastfeedingClinic.ca
Fax: (833) 615-1113
admin@OntarioBreastfeedingClinic.ca
Dr. Michael A. Forrester, MD, PhD, FRCPC, FAAP

## Provider Details (required):

☐ Midwife ☐ Nurse Practitioner ☐ Doctor

Name | Billing Number

Address | Date of Referral

Phone | Fax

**Signature**

***Please inform client of EMAIL booking notifications.***

***Please complete all required fields.***

## Preferred IBCLC*:

IBCLCs are listed online OntarioBreastfeedingClinic.ca

*Clients may request a specific IBCLC, or next available appointment.

Link to CONSENT FORM will be emailed to client and MUST BE COMPLETED BY CLIENT before their appointment is booked.

OBC Clinic Hours:

Monday - Friday 9am-5pm

Closed STAT Holidays

## Reason for Referral (required)

*Maternal issues directly related to infant feeding and nutrition

- ☐ Milk supply*
- ☐ Breast/nipple pain*
- ☐ Previous breast surgery*
- ☐ Pumping breastmilk difficulties*
- ☐ Multiple gestation*

☐ PRENATAL* lactation education

PLEASE ENTER EDD MM/DD/YYYY

- ☐ Latching difficulties
- ☐ Slow weight gain
- ☐ Prematurity
- ☐ Tongue tie
- ☐ Thrush/candida
- ☐ Formula intolerance
- ☐ Disabilities
- ☐ Colic
- ☐ Weaning

☑ Lactation/infant-feeding concerns

(if otherwise unspecified)

Additional History:

## Infant* (required, N/A if prenatal):

*Multiple? Please complete a referral for each baby

Name | Sex | DOB (MM/DD/YYYY)

Health Card Number | VC

Address

## Lactating Parent (required)

Name | DOB (MM/DD/YYYY)

Health Card Number | VC

Email USED FOR BOOKING NOTIFICATIONS

Phone